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Health Subcommittee, Committee on Ways and Means

U.S. House of Representatives

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Chairman Herger, Ranking Member Stark, and members of the subcommittee, I appreciate this opportunity to discuss the 2011 Medicare Trustees Report with you. In his testimony, my fellow Public Trustee Dr. Charles P. Blahous described the basic financial structure of the Medicare program and summarized the major findings of the 2011 Trustees Report. I, accordingly, will confine my statement to the changes that have occurred in the program's financial outlook since the 2010 report and the challenges inherent in any estimate of future Medicare or health care spending.

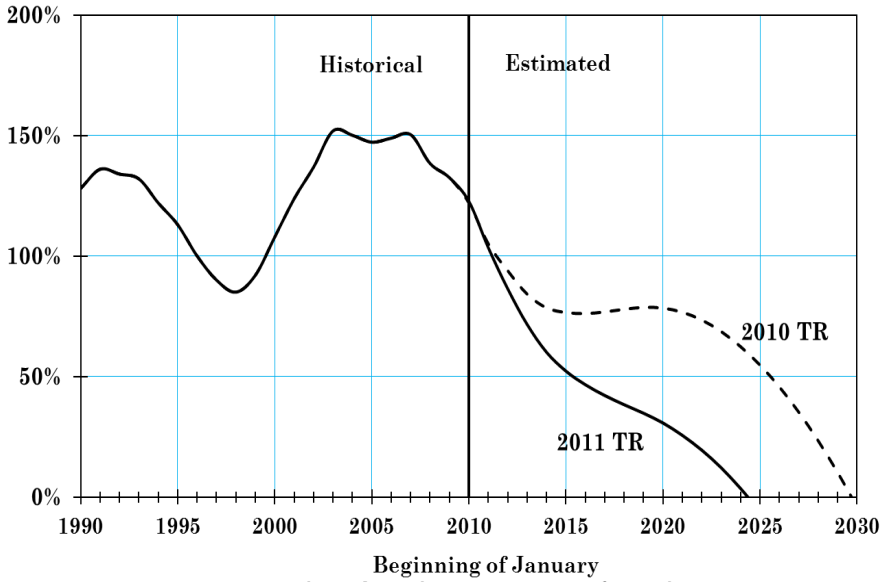
The Trustees' projections of the financial health of the Medicare program change each year, sometimes by small amounts, sometimes by moderate amounts, and sometimes by large amounts. The media and the public tend to focus on the change in the date at which a trust fund is projected to be exhausted as an indicator of how significant the year-to-year change is. In the Medicare program, this makes sense only for the HI trust fund which, like the OASDI trust funds, obtains the preponderance of its income from a dedicated payroll tax, income taxes on a portion of Social Security benefits, and interest on trust fund assets and is precluded from spending more than is available from annual income and accumulated trust fund assets.

The 2011 Trustees Report projects that the Medicare HI trust fund will be depleted in 2024, five years earlier than was projected in the 2010 report (Figure 1). It is worth noting that the date of exhaustion is seven years later than was projected in the 2009 report, the last report prepared before the Affordable Care Act was enacted.

While the five-year deterioration in the date of trust fund exhaustion might suggest that some major changes occurred in policy or in assumptions, that is not the case. Instead, rather small deviations of actual from projected performance in 2010 and small changes in assumptions about the future were enough to move the estimated date of exhaustion five years earlier. Actual HI taxable earnings in 2010 were considerably lower than projected in last year's report. Although real earnings are now assumed to grow somewhat faster over the 2011 to 2019 period, projected real HI payroll tax revenues for the 2011-2024 period are projected to be 1.3 percent lower than in last year's report. While actual HI expenditures in 2010 were fairly close to the previous estimate, faster real earnings growth leads to larger increases in projected real provider payment rates during this period and is the primary reason why real HI expenditures for the 2011-2024 period are some 3.6 percent higher than they were in last year's report.

[1] The views expressed in this statement should not be attributed to the Urban Institute, its sponsors, staff, or trustees.

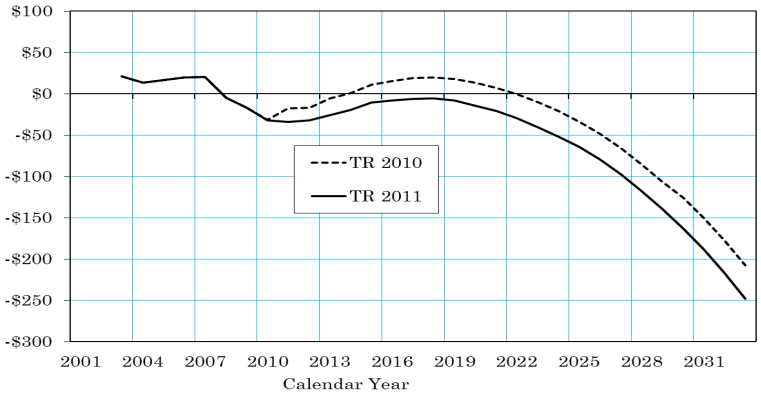
Figure 1—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures, 2010 and 2011 Trustee



Note: Projections are based on the assumptions from the 2011 Trustees Report.

Medicare HI expenditures have exceeded income since 2008. Last year's Trustees report projected that this situation would turn around as the economy recovered and small surpluses would be realized between 2014 and 2022 (Figure 2). Under the new projections, Medicare HI spending is expected to exceed income for the indefinite future.

Figure 2—Annual HI Trust Fund Surpluses(+) or Deficits(-) (in billions)



Note: Projections are based on the intermediate assumptions from the 2011 Trustees Report.

The change in the HI Trust Fund's actuarial balance is a more comprehensive indicator of the change from report to report in Medicare's financial situation. The actuarial balance is the difference between the program's annual income and cost rates averaged over the 75-year projection period.[2] The cost rates reported in the 2011 Trustees Report are slightly higher than those projected last year while the income rates have changed little (Figure III.B6). As a result, the actuarial balance has deteriorated to -0.79 percent from the -0.66 percent estimated in last year's report. The primary factor responsible for this decline is that expenditures were higher and payroll tax revenues lower in the base year, 2010, than was anticipated (Table III.B12) .

Figure III.B6.—Comparison of HI Cost and Income Rate Projections: Current versus Prior Year's Reports

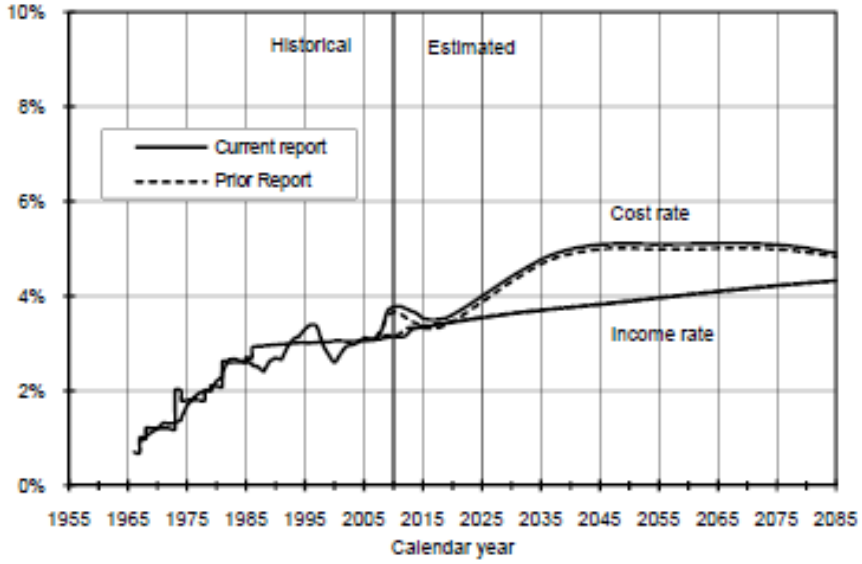


Table III.B12.—Change in the 75-Year Actuarial Balance since the 2010 Report

1. Actuarial balance, intermediate assumptions, 2010 report	−0.66%
2. Changes:	
a. Valuation period	−0.01
b. Base estimate	−0.17
c. Private health plan assumptions	0.04
d. Hospital assumptions	0.03
e. Other provider assumptions	−0.02
f. Economic and demographic assumptions	0.00
Net effect, above changes	−0.13
3. Actuarial balance, intermediate assumptions, 2011 report	−0.79

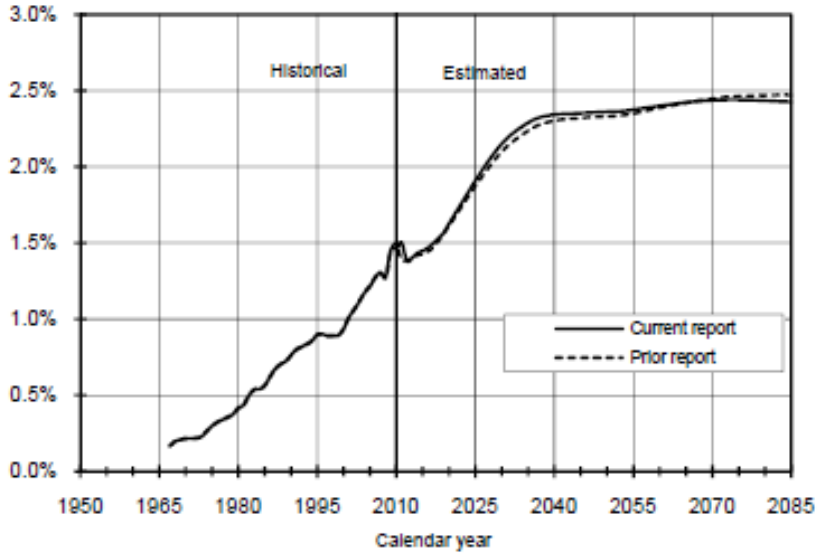
[2] The income rate is the ratio of incurred income from payroll taxes and the taxation of OASDI benefits to HI taxable payroll for the year. The cost rate is the ratio of incurred HI expenditures (excluding those for premium-paying voluntary enrollees and those whose expenditures are reimbursed out of the general fund) to HI taxable payroll for the year.

Whereas the 2010 report estimated that a 23 percent tax increase or a 15 percent reduction in expenditures would be needed to restore actuarial balance over the 75 year projection period, the comparable estimates in the 2011 report are a 24 percent tax increase or 17 percent reduction in expenditures.

By construct, neither of the two SMI trust funds can become depleted, so the changes in the date of trust fund exhaustion and actuarial balances are not relevant indicators with respect to the Part B (SMI) or Part D trust funds. General revenue transfers to the Part B trust fund are set each year to ensure that, together with beneficiary premiums, the program can meet expected costs and maintain an adequate contingency reserve. Part D has indefinite budget authority to draw on general revenues to cover costs not covered by beneficiary premiums and state transfers. For SMI, the relevant measure to focus on is the change from year to year in SMI spending, including premium payments, as a fraction of GDP.

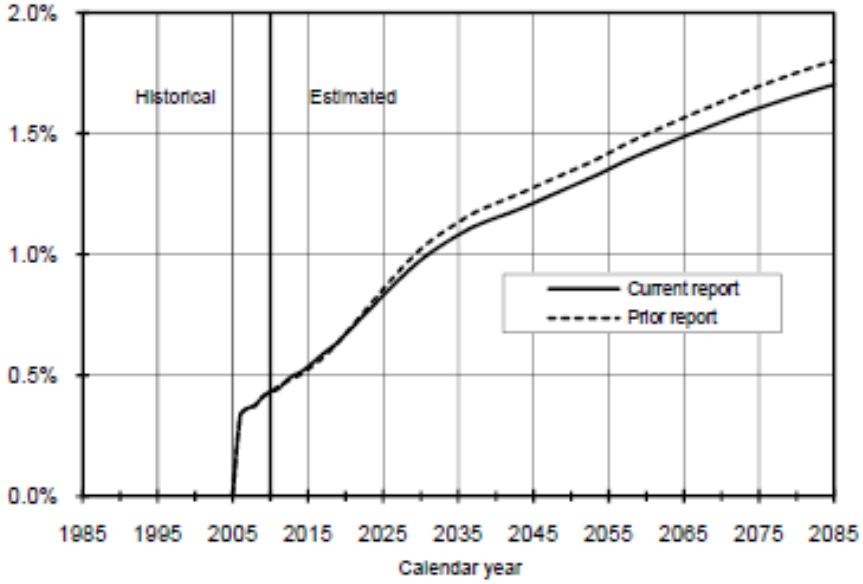
Figures III.C5 and III.C6, which are labeled with their identifiers from the 2011 Trustees Report, and the summary table show that the projections of SMI expenditures relative to GDP changed little between the 2010 and 2011 reports. Relative to GDP, Part B spending is projected to be slightly higher initially but to gradually become slightly lower than the projections in the 2010 report. This pattern reflects lower projected Part B expenditures starting in 2010, relatively lower GDP projections, and a slight refinement in the application of the ACA multifactor productivity adjustments in the long run.

Figure III.C5.—Comparison of Part B Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



In contrast, the 2011 report projects slightly lower Part D spending relative to GDP than was projected in the previous report. The primary explanation for the improved Part D outlook is an assumption that the growth rate for prescription drug expenditures in the U.S. as a whole will be somewhat lower than was assumed in the 2010 report.

Figure III.C6.—Comparison of Part D Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



While the changes between the 2010 and 2011 Trustee reports are relatively small and relate largely to updated economic and other assumptions, differences between projected and actual performance in the base year (which are not unusual), and small refinements in estimating methodologies, the projections remain highly uncertain. This is particularly true over the longer run.

Unlike Social Security, which provides a fairly straightforward and easily defined benefit (retirement income), Medicare provides access to an ever-changing and improving product--health care. It is impossible to predict with any confidence what might be considered adequate health care or its cost a decade or two in the future. New interventions, devices, procedures, therapies, and pharmaceuticals are being introduced every day. New payment systems are being developed, and delivery systems are evolving. It is widely accepted that past cost trends cannot be sustained long unless we are willing to devote the lion's share of our new private and public resources to health care.

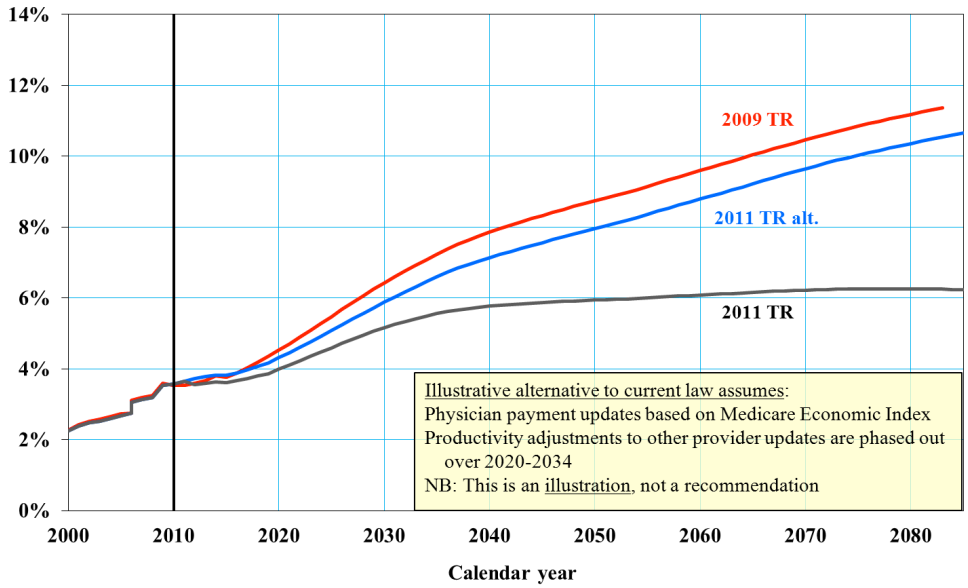
Many promising private initiatives are under way to curb the growth of health costs and improve the quality of care. Through the Affordable Care Act and other measures, the federal government is pursuing the same objectives. To the extent that federal efforts are reflected in law, their estimated impacts on costs are incorporated in the Trustees' projections. In some cases considerable experience suggest that the law will be modified to reduce or eliminate the adverse impacts of cost reduction measures on beneficiaries, providers, and taxpayers. The prime example is the Sustainable Growth Rate (SGR) mechanism that has been fully or partially

overridden in each of the last nine years. Notwithstanding this experience, the projections in this year's Report assume that the 29.4 percent reductions in the physician fee schedule called for by the SGR will go into effect in January 2012, even though Congress and the President are likely to waive the reduction. Were Congress and the President to substitute a MEI update for cuts called for by the SGR, Part B expenditures would be some 12.6 percent higher in 2012 than is estimated in the Report.

For this reason, the estimates in the Trustees Report might be viewed as a relatively optimistic set of projections. To provide a less optimistic picture, the CMS Office of the Actuary has produced an illustrative alternative set of projections for each of the past two years. This scenario significantly changes two assumptions underlying the Trustees Report. First, the SGR system is abandoned and in its place the physician fee schedule is updated each year by the Medicare Economic Index (MEI), which is an index of practice costs inflation minus an adjustment for the growth of economy-wide multifactor productivity. Second, the reduction the Affordable Care Act made to the updates for most other providers to account for economy-wide multifactor productivity is phased out starting in 2020 and ending in 2035.

Figure 3 shows total Medicare expenditures as a percentage of GDP as projected in the 2009 Trustees Report, which was issued before passage of the Affordable Care Act, and as estimated using the assumptions of the 2011 Report and the 2011 Alternative Scenario. Were the Alternative Scenario assumptions to prevail, 81 percent of the improvement anticipated in the 2011 Report from the Affordable Care Act would be lost by 2070.

Figure 3—Total Medicare expenditures as a percentage of GDP, 2009 and 2011 Trustees Reports, and Illustrative Alternative Scenario



Note: Projections are based on the intermediate assumptions from the 2011 Trustees Report.

Just as the assumptions underlying the 2011 Trustees Report might be considered relatively optimistic, the Alternative Scenario might be considered relatively pessimistic. While Congress and the President have not adhered to the discipline called for by the SGR, the updates that they have approved have averaged well below the MEI. Similarly, many provider types have not received full updates in every year. With considerable budgetary pressure on policymakers, average updates could be well below those assumed in the Alternative Scenario if the productivity adjustment were to be abandoned.

Furthermore, innovations being undertaken in the private sector and those stimulated by various provisions of the Affordable Care Act could prove more successful than have been assumed. With the private and public sectors working on the same problem and the provider communities more fully engaged, some optimism may be warranted.

Notwithstanding these possibilities, it is clear from the 2011 Trustees Report that further significant legislative action will be needed to put Medicare on a sustainable, long-run path. The sooner such actions are taken, the more gradual the change can be and the less disruptive it will be for beneficiaries, providers and the taxpayer.